STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004386	A. BUILDING: _____ B. WING _____	R 12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASERACARE HOSPICE	3775 HALEY DR STE B NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	INITIAL COMMENTS This was a revisit for the State re-licensure survey completed on 10-1-13, 10-2-13, 10-3-13, and 10-8-13. Survey Date: 12-18-13 Facility #: 004386 Medicaid Vendor #: 200519300 Surveyor: Vicki Harmon, RN, PHNS During this survey 3 Conditions of Participation and 31 standard level deficiencies were found corrected. Aseracare Hospice was found to be in compliance with the Indiana State Rules for hospice licensure IC 16-25-3 and the Conditions of Participation 42 CFR 418. Quality Review: Joyce Elder, MSN, BSN, RN December 19, 2013	{S 000}		